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I. INTEREST OF AMICI

Amici Joseph E. Lifschutz, M.D., and George R. Caesar, M.D. are psychiatrists in private practice who for decades have had a special concern about the importance of confidentiality in psychotherapy. Both men have had occasion to take particularly firm stands on that subject. Each has taken a principled stand in support of the tenet that in order for patients to be treated effectively in psychotherapy, absolute confidentiality is necessary, and that to disclose patient confidences even under statutory compulsion would fundamentally violate their valued social function as physicians and healers. Dr. Lifschutz and Dr. Caesar were the protagonists in two leading cases which addressed the need for a psychotherapist-patient evidentiary privilege and its constitutional dimensions. *In re Lifschutz*, 2 Cal.3d 415, 85 Cal. Rptr. 829, 467 P.2d 557 (1970); *Caesar v. Mountanos*, 542 F.2d 1064 (9th Cir. 1976) (see especially opinion of Hufstedler, J., concurring and dissenting). Each of them was ordered by a court of law to testify about his patient, refused, and served a brief term for contempt of court, neither having any interest of his own in the matter other than adherence to basic principles of their profession. By their courage, Drs. Lifschutz and Caesar hoped to demonstrate that the professional principles of their profession, one which is clearly essential to the well-being of humankind, are entitled to as much consideration as is the rule of law, and that they warrant the law's accommodation.

The *amicus* San Francisco Psychoanalytic Institute and Society is a teaching institution which trains psychoanalysts. As such, it has a particular concern that confidentiality in psychoanalysis and psychotherapy be properly understood and that the law of privilege give full and proper consideration to the treatment needs of patients receiving psychotherapy and to the betterment of the patients' mental health.

Amici believe that other interested parties will fully develop the legal issues before the Court. They are grateful for the opportunity to emphasize here some of the medical concerns that establish a particular need for confidentiality -- and thus, for privilege -- in order to allow patients to benefit from psychotherapy. *Amici* will also point out that psychotherapy is not a truth-finding activity and that what a patient may say in psychotherapy involves feelings, not facts. The therapist's only purpose in listening is the relief of emotional symptoms and the improvement of the patient's mental health. The ascertainment of objective truth about events in the patient's life, the goal of evidence in the legal system, is not a goal or purpose of psychotherapy.

II. ARGUMENT

A. Introduction.

Every judge and lawyer who has worked in the field of psychotherapeutic confidentiality is aware of the passage by Chief Judge Henry Edgerton which has echoed down through the years:

> [A] psychiatrist must have his patient's confidence or he cannot help him. "The psychiatric patient confides more utterly than anyone else in the world. . . . he lays bare his entire self, his dreams, his fantasies, his sins and his shame. . . .It would be too much to expect them to do so if they knew that all they say - and all that the psychiatrist learns from what they say - may be revealed to the whole world from a witness stand."

Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955), *quoting* M. Guttmacher & H. Weihofen, *Psychiatry and The Law* 272 (1952).

This passage has been repeated in other cases examining the issue of confidentiality in psychotherapy, notably in *In re Lifschutz*, 2 Cal.3d 415, 431, 85 Cal. Rptr. 829, 467 P.2d 557 (1970), and in the case below, *Jaffee v. Redmond*, 51 F.3d 1346 (7th Cir. 1995).[1]/ A main purpose of this brief is to assist the Court by furnishing it material that explains the truth of this passage and the importance of such confidences in the healing process of psychotherapy.

It is important to note that psychotherapy is but one branch of mental health care. The term "mental health care" is used here to encompass every kind of professional assistance to people with mental and emotional difficulties, no matter which professional may provide it. There is of course a hierarchy of care providers, ranging from physicians specializing in mental health called psychiatrists to clinical psychologists, licensed clinical social workers, marriage and family child counselors and many others.[2]/ These mental health workers use a large variety of means to alleviate their patients' suffering, including (among others) commitment to secure wards, the prescription of psychoactive drugs, short-term and long-term psychotherapy and psychoanalysis. While ***all*** aspects of mental health treatment should be protected by the privilege, the analytical reasons and needs for the privilege are especially important to psychotherapy and psychoanalysis.

1/ *See also, e.g., In re Zuniga*, 714 F.2d 632, 638 (6th Cir. 1983); *Hawaii Psychiatric Soc'y v. Ariyoshi*, 481 F.Supp. 1028, 1038 (D. Haw. 1979); *Lora v. Board of Educ. of New York*, 74 F.R.D. 565, 571 (E.D.N.Y. 1977).

2/ California Evidence Code §1010 is typical of statutes dealing with psychotherapist-patient privilege in listing the various kinds of mental health workers whose therapy is protected by that privilege. It includes in that list psychiatrists, psychologists, clinical social workers, school psychologists, marriage, family and child counselors, registered nurses, and various assistants to some of the positions listed above.

In those areas such as medications visits, where the patient reveals few confidences to the clinician, the reason for the privilege is the same as that for the age-old physician-patient privilege: to encourage the patient to seek help while protecting against unnecessary disclosure of matters of great personal embarrassment, such as the symptoms of a psychosis, a history of confinement in a mental hospital and the like. *See, e.g., Buford v. Howe*, 10 F.3d 1184 (5th Cir. 1994); *Petrillo v. Syntex Laboratories, Inc.*, 148 Ill. App. 3d 581, 499 N.E.2d 952, 102 Ill. Dec. 172 (Ill. App. Ct. 1986), *cert. denied*, 483 U.S. 1007 (1987). But the **nature and quality** of the therapeutic process in psychotherapy and in psychoanalysis is different and unique, and there is accordingly an additional and qualitatively different and more far-reaching reason why what the patient tells or the clinician hears and knows as the result of such psychotherapy should be protected through the recognition of a psychotherapist-patient privilege. *Lora v. Board of Educ. of New York*, 74 F.R.D. 565, 575 (E.D.N.Y. 1977).

It may be helpful to distinguish *privacy* from *confidentiality*, as these terms are discussed in the professional literature. The concept of privacy in psychotherapy embraces the idea of limiting the access of others to one's mind, including information about the self that is contained in dreams, fantasies, thoughts, and beliefs. M. Smith-Bell & W. Winslade, *Privacy, Confidentiality, and Privilege in Psychotherapeutic Relationships*, 64 Amer. Journal of Orthopsychiatry 180, 181 (1994). Thus, privacy is the patient's personal and individual right to keep personal matters from public intrusion. *Confidentiality*, on the other hand, characterizes and identifies the physician's treatment of communications made to the therapist within the context of a patient-therapist relationship. Once private information has been disclosed to a therapist with an expectation that such information normally will not be disclosed to third parties, it becomes confidential as to the clinician who heard it. *Id.* at 183. This expectation on the patient's part is essential to the therapeutic process, as we will explain.

B. The Nature of Psychotherapeutic Confidences

A basic tenet of psychotherapy (at least for adult patients) is the requirement that therapist and patient enter into a joint endeavor of consenting adults in what psychotherapists actually call a *therapeutic* or *working alliance*. H. Kaplan & B. Sadock, *Synopsis of Psychiatry* 573 (1991). Both parties commit themselves to exploring the patient's most deep-seated, even unconsciously lodged concerns, to establishing an absolute mutual trust, and to cooperating with each other to achieve a realistic goal of the cure or amelioration of the patient's symptoms, illness or distress. In fact, it is generally recognized that this very close confidential quality of the psychotherapist-patient relationship is of equal, if not greater importance to successful treatment than what is actually said during treatment. G.S. Truant & J.G. Lohrenz, *Basic Principles of Psychotherapy*, 47 Amer. Journal of Psychotherapy 8, 25 (1993).

Full, open and honest communication is essential to fostering an effective therapeutic relationship. G.S. Truant & J.G. Lohrenz, *supra*, at 16. Clinicians learn to encourage their patients to talk in detail about emotionally significant aspects of their experiences, expressing the patients' feelings and in more extensive therapy, also their fantasies. *Id.* at 13. Invariably, this means that their patients will talk -- at length and on occasion in pain -- about the patients' thoughts, feelings and behavior and how they experience themselves and their key relationships, including the one with the therapist. *Id.* Building this trust -- called the therapeutic alliance -- is one of the first tasks the clinician faces. Therapeutic relationships are often tentative and fragile until the patient can come to trust the therapist with intimate details of the patient's life and feelings. *Id.* at 184.

This strong relationship of trust is crucial to the psychotherapeutic technique of *free association* -- the patient's verbalizing everything that comes to mind without censorship, regardless of the patient's belief in the thought's unacceptability, unimportance or capacity to embarrass or shame. H. Kaplan & B. Sadock, *supra,* at 573. Free association is a *sine qua non* of any extensive psychotherapy. This process may take months or longer before the patient will bring up in therapy deeply hidden psychological fears and traumas, with which the clinician then helps the patient come to terms. Thus is the patient helped to better mental health.

Without a promise of complete confidentiality, the patient would become very much more reluctant to bring this hidden material to light. It is thus the psychotherapist's function, in part, to analyze the freely associated material as it relates to the patient's cognitive processes and to any neuroses or psychoses from which the patient may suffer. This unique process generates statements and revelations which may be wholly or partially distorted or even imaginary -- i.e., fictitious -- and thus often particularly unsuitable for the truth-finding function of legal process.

C. There Is A Special Need For Confidentiality In Psychotherapy

The Hippocratic Oath, sworn by physicians since ancient times, states in part, "And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets." 1 *Hippocrates* 301 (W. H. Jones trans. 1923), *reprinted in* S. Reiser, *Ethics In Medicine: Historical Perspectives And Contemporary Concerns* 5 (1977). Hippocrates's injunction has special meaning in the field of psychotherapy: "[t]he principle of confidentiality is of unique importance in psychoanalysis because some of the information actively sought in the relationship has been

unconscious; that is, what is revealed is often not acceptable to the patient." *Psychoanalytic Terms and Concepts* 44 (B. Moore & B. Fine eds. 1990). As one might expect, it is often difficult to help a patient uncover, understand, and accept this unconscious information, and it cannot be done without the patient's cooperation. Unless a patient trusts that these intensely personal expressions will not be shared with others, it is unlikely that the patient will cooperate fully in the therapy. M. Smith-Bell & W. Winslade, *supra,* at 180. "The disclosure of one's self to one's self can be difficult enough. There is usually some increment of displeasure from the necessary psychic exposure to the analyst. There should be no danger of further distress from the possibility of the analyst's exposure of the patient to anyone else." A. Watson, *Levels of Confidentiality in the Psychoanalytic Situation*, 20. J. Amer. Psychoanalytic Assn. 156, 157 (1972).

1. Without confidentiality, most patients would forego treatment

If a psychotherapist-patient privilege were widely denied, the practice of psychotherapy would be damaged in at least two major ways. The first is implied by the unique reasons underlying the necessity for the privilege. During therapy, a patient is encouraged to say whatever comes to his mind, without self-censorship. "In order to do this, he must trust that the clinician will not take him at his word, but instead will regard the expression of thought as the means to liberate unconscious ideas, memories and feelings that contribute to his mental suffering and disturbed relations." C. Bollas & D. Sundelson, *The New Informants* 61 (1995). If the patient cannot trust that his expressions will be used only in this way--because he is aware, at some level, that the psychotherapist may at some future time be compelled to repeat those expressions outside the therapeutic context--and therefore feels free to discuss only part of his thoughts, "the entire procedure would come to a halt. It is not possible to be unconsciously selective in this way." Id.

2. Without privilege, psychotherapists would be unable to provide proper treatment

In addition to the effect that denial of privilege would have on patients, less obvious but no less insidious is the deleterious effect that such a denial would have on psychotherapists. The psychotherapist is very much an active participant in the therapy session, even when she is not speaking. The psychotherapist must allow herself to explore the same psychic terrain as the patient. The therapist serves as a "blank screen" for the reception of the patient's experience and psychic stresses. The patient unconsciously understands how completely receptive the analyst is being, and is thus emboldened to express more fully her internal world. Id. at 88. However, when the psychotherapist is concerned--consciously or unconsciously--that the therapist may have to disclose to third parties the words the patient has used to express her inner world, or otherwise violate the patient's confidence, the analyst's "screen" is no longer blank, and the resulting distraction prevents the therapist from being fully receptive to the patient's inner world. Id. at 89-90.[3/]

D. Statements Made During Therapy Do Not Generally Aid The Truth-Seeking Process

A common objection to the establishment of *any* testimonial privilege is that it impedes access to relevant evidence and therefore obstructs the truth-finding process. Indeed, the petitioner has strenuously advanced the position that recognition of a psychotherapist-patient privilege would exclude "crucial evidence." Brief for Petitioner at 21-25.

3/ This argument should not be taken as a claim that the therapist is entitled to assert a privilege for her own benefit. It is the patient whose therapy is impeded if the therapist listens to the patient with one ear cocked, so to speak, to be alert for an outside intrusion into the intimacies of the therapeutic process.

Whatever the force of this objection when applied to other privileges, in the context of a psychotherapist-patient privilege it is most misleading and should carry very little weight. The argument assumes that the evidence shielded by the privilege is accurate, truthful evidence, whose consideration will perforce aid the search for truth. However, the nature of statements made by patients to psychotherapists counsels that admission of such statements might actually degrade the truth-finding process. This is so because statements made by patients to psychotherapists are quite often not "true" in the sense we commonly understand the term.

As we have seen, the object of psychotherapy is to allow the patient to "work through" her secret and even unconscious feelings, by speaking them out loud in the intimate and nonjudgmental environment of a therapy session. It is not at all uncommon that a patient will express deeply buried, socially unacceptable assertions to the therapist which may sound like facts to an outside listener -- "my father abused me as a child;" "I killed my brother" -- but which the therapist understands may be expressions of deeply buried fears, anxieties or other feelings, not "true" in the truth-finding sense at all.

Thus while of course we have no knowledge of what Ms. Redmond may have said in her many therapy sessions with her therapist, it is entirely conceivable that in agony about having taken a human life, she might more than once have stated there, *as a fact,* that she could have conducted herself in ways which would have averted the tragedy. This type of self-reproach is to be expected in working through the stress and grief of such a tragic event, but no one should mistake it -- if indeed it was said -- as the speaker's objective, truthful description of the actual events. It may or may not be that; but one can be certain that there would be little reason for it to have been given to the therapist as a statement of the objective truth.

The American Psychiatric Association's standard and comprehensive textbook, *Treatments of Psychiatric Disorders*, describes a case history analogous to that found in this case, and thereby provides an example of how statements made in therapy may not represent "truth" as it is sought in a courtroom. An experienced lifeguard was faced with an exceptionally busy summer day. The demands on his attention mounted to the point where he realized he could not be sure that everyone was safe. As a result, "[h]e blew his whistle and ordered the pool cleared. To his horror there was an inert body at the bottom of the pool." American Psychiatric Association, 3 *Treatments of Psychiatric Disorders* 2078 (1989). The lifeguard dove into the pool, brought out a small boy, and attempted to resuscitate him. He was unsuccessful: the child was dead. Id.

After the tragedy, the lifeguard began to have nightmares, seeing the child's face blurred as if under water, or as it appeared before the attempted resuscitation. The lifeguard eventually entered therapy for treatment of post traumatic stress disorder. Id. During the course of his therapy, "an important and repetitive activity was to attempt to disentangle the realistic aspects of his responsibility as a lifeguard for the safety of everyone in the pool *and his fantasy elaborations of reasons why he was terribly guilty*." *Id.* at 2078-79 (emphasis added). In other words, the lifeguard told the therapist that it was all his fault the child died. But that wasn't "true" in an objective sense. The lifeguard's statements to that effect were the "fantasy elaborations" of a mind temporarily unable to come to grips with a terrible tragedy. The psychotherapist recognized them as such, and used them to help the patient *resolve his feelings* about the tragedy.

However, a jury might well not have known that the statements were fantasies. Had the lifeguard been on trial for the death of the child--instead of Marylu Redmond on trial for the death of a knife-wielding assailant--plaintiff would no doubt have vigorously opposed any claim of privilege,

arguing as petitioner does, that the tortured professions of guilt were "crucial evidence" that the jury was entitled to hear and consider in its search for truth. The case history makes clear, however, that the lifeguard's statements were not "true" in the sense that the plaintiff would want the jury to believe. It would be *the admission* of these psychotherapist-patient statements, not their suppression, that would distort the legal system's search for truth. "Certainly, a court has no interest in allowing an individual's case to be prejudiced by narrations of his fantasies." Comment, *The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved*, 34 Emory L.J. 777, 802 (1985).

In a therapy session, "it does not matter from an epistemological point of view whether a patient's statement is literally true or false." D. Spence, *The Special Nature of Psychoanalytic Facts*, 75 The International Journal of Psycho-Analysis 915, 915-16 (1994). In a courtroom it matters very much. This distinction between the "truth" sought in therapy and the "truth" sought in court, and the fact that much of what is said in therapy is not "true" in the way the law uses that word, demonstrates how uniquely deserving and indeed needy psychotherapist-patient communications are of the protection of privilege--as well as how little if any damage such a privilege would do to the legal system's search for truth.

E. A Privilege For Psychiatrist-Patient Communications Meets The Definitions By Which Privileges Have Historically Been Recognized.

Privileges have historically been recognized as necessary to protect against the destructive impact that disclosure of confidential information would have on certain relationships involving ultimate trust. The concept which undergirds the law of privilege is that some relationships are

considered so valuable to society that full candor in these relationships should be fostered by preserving the confidentiality of what is revealed there, even though evidence which might aid in the quest for truth would be lost. *Baylor v. Mading-Dugan*, 57 F.R.D. 509 (N.D. Ill 1972).

There are four fundamental factors which are found in all recognized privileges:

> (1) the communications originated in a *confidence* that they will not be disclosed; (2) this element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties; (3) the *relation* must be one which in the opinion of the community ought to be sedulously *fostered*; and (4) the *injury* that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of litigation.

8 J. Wigmore, *Evidence* §2285 (J. McNaughton rev. 1961). Only if these four conditions are present should a privilege be recognized. Id.

All four elements exist in the psychotherapist-patient relationship. First, as discussed above, communications between psychotherapist and patient originate with an understanding that there will be complete confidentiality. Often a patient conceals from associates, relatives and co-workers even the fact that he or she is considering psychotherapy. In that therapy, a patient often discloses feelings about associates, relatives, co-workers and his or her self that the patient may not even anticipate, and certainly does not wish to make known to others. The threat of disclosure would be the ultimate threat to the patient's

privacy. That threat may deter many from seeking much-needed therapy.

Second, confidentiality is essential to the development and the realization of the psychotherapist-patient relationship. As explained in Part II.D. above, complete trust and confidentiality in that relation is of utmost importance for a patient to feel safe enough to unburden his or her innermost thoughts to the therapist. The analyst, meanwhile, must be able to clear her mind and be totally receptive to the patient's psychic stresses. But it is impossible to achieve this state of receptiveness if a part of the analyst's mind is concerned with the possibility that the analyst may one day be forced to use the patient's confidences to hurt the patient rather than to heal him.

Third, because the mental health of each individual member of society has long-term effects on society as a whole, there can be no doubt that society has a great interest in the mental health of its members. Mental illness often results in societal burdens such as juvenile delinquency, marital strife, violent crime, and the great cost of caring for the mentally ill. "The societal interest in protecting the confidentiality of therapy is to promote emotional and mental health, which ultimately will reduce antisocial activity and other societal burdens that result from untreated or poorly treated mental problems." S. Smith, *Constitutional Privacy In Psychotherapy*, 49 Geo. Wash. L. Rev. 1, 39 (1980). Society as a whole undoubtedly considers the psychotherapist-patient relationship one that should be sedulously fostered.

Finally, the injury that would result from disclosure is far greater than any benefit gained in litigation. "Disclosure of communications to psychotherapists and their diagnoses would frequently be embarrassing to the point of mortification for the patient." *In re Doe*, 964 F.2d 1325 (2nd Cir. 1992). Not only would such disclosure result in psychological harm to the patient but it would chill future

communications with the therapist, resulting in impairment of the therapist's ability to render the help needed, and possibly, premature termination of therapy. On the other hand the benefits gained from disclosure for the correct disposal of litigation are unclear and unreliable. As noted earlier, the confidences disclosed during therapy offer very little reliability as to truth or accuracy.[4/]

The arguments favoring a psychotherapist-patient privilege are at least as strong as those found sufficient to support the long-recognized attorney-client privilege. The attorney-client privilege was developed to promote candid consultation with legal advisors by the client and to maximize the lawyer's unhampered access to information which would insure the presentation of the best possible case at trial. *Matter of Walsh*, 623 F.2d 489, (7th Cir. 1980) *cert. denied*, 101 S. Ct. 531 (1980); *United States v. Hodge and Zweig*, 548 F.2d 1347 (9th Cir. 1977); *International Business Machines Corp. v. Edelstein*, 526 F.2d 37 (2d Cir. 1975). In similar fashion, the therapist-patient privilege is essential to protect the patient by encouraging full and confidential disclosure to the therapist of all information, however embarrassing, frightful, or horrific, which might aid the therapist in helping the patient achieve mental balance and peace.

4/ This is not the case to speak to exceptions to the psychotherapist-patient privilege which the law of most jurisdictions has established, though petitioner's brief devotes much attention to them. Before there can be exceptions, there must first be recognition of the privilege itself. Whether that privilege should be recognized and which therapists should be included in it are the issues on which certiorari was granted. If this Court recognizes the privilege, exceptions to its application can be developed as occasions may arise. It can safely be said, however, that nothing in this virtually classic record of an extended psychotherapeutic treatment approaches any of the circumstances in which exceptions to an extant privilege have been recognized anywhere.

Thus, by all factors historically used to support the finding of privileged communications, the psychotherapist-patient relationship should be recognized as a relationship in which confidentiality must be preserved.

F. The Psychotherapist-Patient Privilege Is Firmly Rooted In The Federal Right To Privacy

1. The privilege is supported by the cases establishing a right to privacy

In *Carey v. Population Services Int'l*, 431 U.S. 678 (1977), this Court restated the parameters of the right to privacy as protected by the federal constitution, as developed to that point in time:

> Although "[t]he Constitution does not explicitly mention any right of privacy," the Court has recognized that one aspect of the "liberty" protected by the Due Process Clause of the Fourteenth Amendment is "a right of personal privacy, or a guarantee of certain areas or zones of privacy." *Roe v. Wade*, 410 U.S. 113, 152 (1973). This right of personal privacy includes "the interest in independence in making certain kinds of important decisions." *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977). While the outer limits of this aspect of privacy have not been marked by the Court, it is clear that among the decisions that an individual may make without unjustified government interference are personal decisions "relating to marriage, *Loving v. Virginia*, 388 U.S. 1, 12 (1967); procreation, *Skinner v. Oklahoma ex rel.*

Williamson, 316 U.S. 535, 541-542 (1942); contraception, *Eisenstadt v. Baird*, 405 U.S., at 453-454; *id.*, at 460, 463-465 (White, J., concurring in result); family relationships, *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); and child rearing and education, *Pierce v. Society of Sisters*, 268 U.S. 510, 535 (1925); *Meyer v. Nebraska*, [262 U.S. 390, 399 (1923)]."

Id. at 684-85 (quoting *Roe v. Wade*, 410 U.S. 113, 152-53 (1973)). The Court has also noted that the privacy right, by definition, involves "the most intimate of human activities and relationships." *Id.* at 685.

Although this Court has never decided whether a right to privacy inheres in the doctor-patient relationship generally, *see Planned Parenthood v. Casey*, 505 U.S. 833, 112 S. Ct. 2791, 2824 (1992) (leaving undecided "[w]hatever constitutional status the doctor-patient relation may have as a general matter"); *cf. Whalen v. Roe*, 429 U.S. 589 (1977), the protection of psychotherapeutic communications which the psychotherapist-patient privilege is designed to serve fits squarely within the principles of the privacy right as pronounced in *Carey*. Unlike most information conveyed to a doctor treating physical ailments, the information communicated to a psychotherapist in the course of therapy concerns virtually without exception "the most intimate of human activities[,] . . . relationships" and thoughts. *Carey*, 431 U.S. at 685. In the words of one court, "[n]o area could be more deserving of protection than communications between a psychiatrist and his patient. Such communications often involve problems in precisely the areas previously recognized by the [Supreme] Court as within the zone of protected privacy, including family, marriage, parenthood, human sexuality, and physical problems." *Hawaii Psychiatric Soc'y v. Ariyoshi*, 481 F.Supp. 1028, 1038 (D. Haw. 1979).

Recognizing the similarities between psychotherapeutic communications and the intimate spheres of decision accorded constitutional solicitude under the right to privacy, several state and federal courts have decided that the psychotherapist-patient privilege is grounded in the constitutional right to privacy. The first court to do so, of course, was the California Supreme Court in *In re Lifschutz*, 2 Cal.3d 415, 85 Cal. Rptr. 829, 467 P.2d 557 (1970). There the court said:

> We believe that a patient's interest in keeping such confidential revelations from public purview, in retaining this substantial privacy, has deeper roots than the California statute and draws sustenance from our constitutional heritage. In *Griswold v. Connecticut, supra*, 381 U.S. 479, 484 [14 L.Ed.2d 510, 514], the United States Supreme Court declared that "Various guarantees [of the Bill of Rights] create zones of privacy," and we believe that the confidentiality of the psychotherapeutic session falls within one such zone.

Id. at 432. *See also, e.g., In re Zuniga*, 714 F.2d 632, 638 (6th Cir. 1983); *Hawaii Psychiatric Soc'y v. Ariyoshi*, 481 F.Supp. 1028, 1038 (D. Haw. 1979); *Lora v. Board of Educ. of New York*, 74 F.R.D. 565, 571 (E.D.N.Y. 1977).

2. The scope of the privilege is correctly drawn in Judge Hufstedler's opinion in *Caesar*

The opinion of the *Lifschutz* court was essentially followed by the Ninth Circuit in *Caesar v. Mountanos*, 542 F.2d 1064 (9th Cir. 1976), which also found that the privilege was grounded in the right to privacy. *Id.* at 1067

n.9. However, *amici* believe that the superior position was not the position of the two majority opinions but that of Judge Hufstedler, writing in concurrence and dissent in *Caesar*. Judge Hufstedler criticized *Lifschutz* for "incorrectly assess[ing] the weight of the patient's right of privacy as against competing public and private rights in the production of evidence in personal injury litigation." *Id.* at 1071. Despite finding that the "confidential communications between a psychotherapeutic patient and his doctor have the indicia to place those communications squarely within the constitutional right of privacy," *id.*, Judge Hufstedler nonetheless found that a limited intrusion on the constitutional right was warranted. Judge Hufstedler proposed a limited exception to the privilege allowing a party to discover the fact of treatment, the cost of treatment and the ultimate diagnosis, but no more, unless the party could establish a compelling need to obtain the substance of the therapeutic communications. *Id.* at 1075. Judge Hufstedler would thus allow the state to intrude upon the zone of privacy created by psychotherapist-patient communications, but only to a limited degree: under Judge Hufstedler's test, psychotherapeutic communications would seldom be subject to disclosure.

Recent United States Supreme Court precedent suggests that Judge Hufstedler's resolution of the issue strikes the appropriate balance. In *Planned Parenthood v. Casey*, 505 U.S. 833, 112 S. Ct. 2791 (1992), the Court held constitutional a state statute requiring doctors to give certain information to women considering abortion, and mandating a 24-hour waiting period between the provision of that information and exercise of the woman's capacity to give informed consent for the procedure. The Court held that the statutory provisions did not constitute an unconstitutional "undue burden" on a woman's right to an abortion before fetal viability, because the provisions did not place a "substantial obstacle" in the path of a woman seeking such an abortion. *Id.* at 2821. In reaching this holding, the Court gave particular emphasis to the fact that the Pennsylvania

statute there in issue required the giving of truthful, nonmisleading information about the abortion procedure and its alternatives, a resolution which did not unduly invade the abortion patient's privacy. *Id.* at 2823.

If this analysis is used to determine the scope of the right to privacy in the psychotherapist-patient context, it is clear that testimony cannot be compelled concerning *the substance* of confidential communications made during such therapy. As set out earlier, expected and actual confidentiality is crucial to successful psychotherapeutic treatment. Were that confidentiality eliminated, it would not only place a "substantial obstacle" in the path of a person seeking psychotherapy, but in many cases it would make it impossible for a person even to consider confiding the secret troubles that psychotherapy can uniquely address. A requirement that a patient (or her therapist) reveal confidences shared in therapy would thus place an "undue burden" on the patient's right to seek and receive psychotherapy treatment, and would thus violate the zone of privacy surrounding the psychotherapist-patient relationship.

Furthermore, the *Casey* court noted the importance that the information which the state required women to have was "truthful, nonmisleading" information, and found a significant state interest in providing such information to women seeking abortions. *Id.* at 2823. Here, of course, the government seeks through legal process to force the patient (or her doctor) to *reveal*, rather than receive, information. But the state's interest in the revelation of that information is not similarly weighty, because the information it seeks is not generally likely to be "truthful, nonmisleading" information. Instead, as explained above, such "information" is heavily weighted toward exaggeration, distortion and fantasy--products of a mind that is almost by definition not coping well with one or more aspects of reality. This information is not "truthful" in the judicial sense, and therefore it is not "nonmisleading." The government thus has little or no legitimate interest in forcing its revelation under

circumstances which call out to keep the material private. Balanced against the weighty--indeed, indispensable--privacy concerns surrounding the psychotherapist-patient privilege, the government's demand for the confidential communications must fail.

Judge Hufstedler's resolution of the issue delineates the proper parameters of the relevant privacy concerns. The limited, objective information she proposes to require in her opinion in *Caesar* is "truthful [and] nonmisleading," and probably would not place a "substantial obstacle" in the path of those who need and seek psychotherapeutic treatment. The information--perhaps most notably, the diagnosis--would nevertheless aid the legal system in determining whether there existed a compelling need for further disclosures. In keeping with the gravity of the constitutional privacy right attending the psychotherapeutic relationship, however, seldom would such a showing be possible.

But it must be remembered that the critical issue in this case is not where the limits of the privilege should be drawn. It is whether a psychotherapist-patient privilege should be recognized at all "in the light of reason and experience," as Rule 501 of the Federal Rules of Evidence directs. Due consideration of the competing interests of the search for truth and the protection of those interests of privacy and confidentiality which inhere in psychotherapeutic treatment clearly points toward recognition of that privilege.

III. CONCLUSION

Psychotherapy as we know it today had its origin with Sigmund Freud about 100 years ago. It has become a widely available treatment only in the last fifty years. However, its healing uses have become well established within that short time period, so that "the principles of the common law, . . . interpreted . . . in the light of reason and experience" (Rule 501, Federal Rules of Evidence) strongly

point to the recognition of a psychotherapist-patient privilege by this Court.

The judgment of the Court of Appeals should therefore be affirmed.

Respectfully submitted,

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